MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-C

CERTIFICATE OF DEATH

11224 245

Reg. Diat. No.

1. PLACE OF DEATH:

County: Prince George

City or town: East Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred: 6301 - Edmonston Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: East Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6301 - Edmonston Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Edward Baines

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lina Baines

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 10, 1867

8. AGE:	Years	Months	Days	If less than one day
	77	10	28	hrs. min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Copper

FATHER — 12. Name: James E. Baines

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Emma French

MOTHER — 15. Birthplace: England

16. Informant: James H. Baines

Address: 6301 - Edmonston Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 - 10 - 45 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location: Wash. D.C.

18. Funeral director: J. William Leis Sons

Address: 300 - 4th St. N.E.

19. 11/8 1945 (Date rec'd by registrar) Amanda Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1945, at 9 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage	
Shock	
Due to: gun-shot wound	
of head	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Suicide Date of 11-8-45

Where did injury occur? East Riverdale (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Gun-shot. Injured at work? No

Deputy medical Examiner

23. SIGNATURE: James J. Bond M. D. or other

Address: Forestville Md. Date signed 11-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

1122-245

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Berwyn Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Canary Camp

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Claude Randolph Bishop, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1939

8. AGE: Years: 6 Months: Days: 28 If less than one day: 9 hrs. min.

9. Birthplace: Washington, DC (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: Claude R. Bishop

13. Birthplace: Charlottesville, Va

MOTHER 14. Maiden name: Maud Hopp

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Riverdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 15, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: J. Bleacher sons

Address: Hyattsville Md.

19. Nov 15 1945 (Date rec'd by registrar) James Devers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 13 1945, at 9.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident, Auto Date of Nov 13, 1945

Where did injury occur? Berwyn (City or town) P. Geo (County) Md (State)

Injured at home, farm, industry, public place (where?): Public Highway

Means of injury: Fall from auto Injured at work?

23. SIGNATURE: John J. Maloney Acting Deputy Md. Examiner M. D. or other

Address: Hyattsville, Md Date signed: 11-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11226

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred: Mills Jones Rest Home
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4417 28th St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ida D. Bittle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James F. Bittle
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 4 1869

8. AGE: Years	Months	Days	If less than one day
76	8	18	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: Charles W. Fry
FATHER — 13. Birthplace: Md
MOTHER — 14. Maiden name: Mary Goodman
MOTHER — 15. Birthplace: Md
16. Informant: John E. Bittle
Address: 4417 28th St Mt Rainier Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25, 1945 (month) (day) (year)
Cemetery or crematory: Reformed
Location: Knoxville Md
18. Funeral director: L. H. Feete & Bro
Address: Brunswick Md.
19. Nov. 22, 1945 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1945 at 1:10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-20-45 1945 to 11-22-45 1945 and that I last saw h.. alive on 11-21-45 1945

	DURATION
Immediate cause of death: Myocardial failure	3 days
Due to: Hypertensive cardio Vascular renal disease	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M.D. M. D. or other
Address: Hyattsville Md Date signed 11-22-45

VS A15

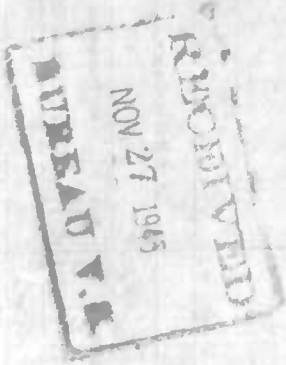
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Lorena

4309

Forquett



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-)

11227

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Leland Memorial Hosp., Riverdale, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4904 - 47th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Maude Ermentaude Blackerby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Fem.	White	widowed

6.(b) Name of husband or wife: William Thornton Blackerby
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1876

8. AGE: Years	Months	Days	If less than one day
69	—	18	hrs. min.

9. Birthplace: Pennsylvania (town, county, and state)
10. Usual occupation: Retired fed. gov. employee
11. Industry or business: Federal government.

FATHER
12. Name: William Henry Oheolthger
13. Birthplace: Pa.

MOTHER
14. Maiden name: Annie Bidson Smallwood
15. Birthplace: Pa.

18. Informant: Pt. Chart
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-1-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash. D.C.
18. Funeral director: HW Chambers Co
Address: Riverdale Md.

19. Nov. 30, 19 45 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-28- 19 45 at 11:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 45 to Nov 28 19 45
and that I last saw her alive on Nov 28 19 45

Immediate cause of death	DURATION
Intestinal obstruction	1 mo.
Due to: Adhesions constricting small intestines	
Due to:	
Other conditions: Fibroid uterus	45 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Adhesions of small intestine & Uterus causing obstruction Date of op. 11-26-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L.O. Malin M.D. (M. D. or other)
Address: Riverdale, Md. Date signed 11-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9520)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twelve days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? Twelve days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Henry Maynard Bowman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Mary Elizabeth Peters
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1876

8. AGE: Years	Months	Days	If less than one day
69		11	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER 12. Name: Augustus Bowman
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret ? ?
MOTHER 15. Birthplace
16. Informant: Patient's chart
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/13/45 (month) (day) (year)
Cemetery or crematory: Brookville Cemetery
Location: Brookville Md.
18. Funeral director: Ernest C Gaburo
Address: Gaithersburg Md
19. Nov 11 1945 James Devery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 1945 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to Nov 10 1945 and that I last saw h... alive on Nov 10 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	1 mo
Due to: Arteriosclerotic Heart Disease	10 yrs
Due to:	
Other conditions: Left Hemiplegia	1 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. W. Mahon MD
M. D. or other
Address: Riverdale, Md Date signed: 11-11-45

11229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges

City or town North Englewood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Mnts

Hospital, Institution, or street address where death occurred: 5711 - [redacted] Reed Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State New Jersey County

City or town Elizabeth (If outside city or town limits, write RURAL and give nearest town)

Street No. 939 - Kenneth Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Joseph Bradhurst Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Susana Bradhurst 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1873

8. AGE:

Years	Months	Days	If less than one day
72	1	1	hrs. min.

9. Birthplace New York (Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business U. S. Govt

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Blanche Huston

Address 5711 - Reed St North Englewood, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4, 1945 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Maryland

18. Funeral director Thomas F. Murray

Address 2007 - Nichols Ave S E

19. Nov. 4 1945 (Date rec'd by registrar) Howard J. Beach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute pulmonary edema	
Due to Congestive heart failure	
Due to Cardiovascular renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE James J. Long M.D. or other

Address Westville Md Date signed 11-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-24)

CERTIFICATE OF DEATH

11230

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pr. Geo. Co.
City or town: Cottage City ~~4018 Parkwood St~~
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
4018 - Parkwood Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicom.
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Howard Peyton Bradley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ella Matilda Bradley
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Nov. 3 - 1873

8. AGE: Years	Months	Days	If less than one day
72	0	14	hrs. min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Retired Gov. Clerk
11. Industry or business:
12. FATHER — Name: F. J. Bradley
13. FATHER — Birthplace: md
14. MOTHER — Maiden name: Emily Howard
15. MOTHER — Birthplace: Maryland
16. Informant: Beulah Fischetti
Address: 4018 Parkwood St. Cottage City md
17. Burial, cremation, or removal. Which?: Burial Date thereof: 11-17-45 (month) (day) (year)
Cemetery or crematory: Nelsons Cemetery
Location: Hebron md.
18. Funeral director: Lowe Chapman & Co
Address: Riverdale md
19. 11/17 1945 Amanda Deaney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-17- 1945, at 3304 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James H. Ford M. D. or other
Address: Forestville Md Date signed: 11-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11231

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 8 mos., 15 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 8 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 810- 5th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Walter C. Brady

3.(b) Social Security Number: 579-18-6138

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married (separated)

6.(b) Name of husband or wife: Elizabeth B. Brady
6.(c) If alive, give age: ?
7. Birth date of deceased (mo., day, yr.): January 21, 1897

8. AGE: Years	Months	Days	If less than one day: hrs.	mins.
48	9	26		

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Barber
11. Industry or business:
FATHER — 12. Name: C. O. Brady
13. Birthplace: Prince George's Co., Maryland
MOTHER — 14. Maiden name: Mary Day
15. Birthplace: Prince George's Co., Maryland
16. Informant: Decedent
Address:
17. Burial, cremation, or removal. Which?: Removal — Date thereof: Nov 16/45 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location:
18. Funeral director: Roberts Mattingly
Address: 131. 11- St S E Washington D.C.
19. 11/16/45 (Date rec'd by registrar) Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 – 16 1945, at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 – 1 1944, to 11 – 16 1945
and that I last saw h. i. m. alive on 11 – 16 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis for advanced	10 yrs.
Due to: Tuberculous Laryngitis	2 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11232

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 26 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1471 Monroe St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: DELIA A. BROWN

3.(b) Social Security Number: 578-03-1321

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married (separated)

6.(b) Name of husband or wife: Vernon Milo Brown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): August 11, 1907

8. AGE: Years	Months	Days	If less than one day
38	3	16	...hrs. ...min.

9. Birthplace: Fairfax County, Virginia
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER
12. Name: William L. Jenkins
13. Birthplace: Fairfax County, Virginia

MOTHER
14. Maiden name: Cora B. Burgess
15. Birthplace: Fairfax County, Virginia

16. Informant: Decedent
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30, 1945 (month) (day) (year)
Cemetery or crematory: Forrestville Cemetery
Location: Fairfax Co., Virginia

18. Funeral director: W. W. Chamberlin & Co.
Address: Washington, D. C.

19. Nov. 27, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 27 Tue 1945, at 7 50 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1944 to Nov 27th 1945 and that I last saw h.er alive on Nov 27 Tue 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to	9 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other

Address: Glenn Dale, Md Date signed: 11/27/45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

11233

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 8 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 729-2nd St. S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Brown, George Henry Jr.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 30, 1921

8. AGE: Years	Months	Days	If less than one day
24	5	15	..... hrs. ..... min.

9. Birthplace: Newborn, North Carolina
(Town, county, and state)

10. Usual occupation: Cafeteria Work

11. Industry or business: —

FATHER — 12. Name: George Henry Brown
13. Birthplace: Newborn, North Carolina

MOTHER — 14. Maiden name: Doreathea Brock
15. Birthplace: North Carolina

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: 11-14-45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Hall Bros.

Address: 621 Fla Ave. N.W. Wash D.C.

19. Nov 14 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-14 1945, at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6 1945, to 11-14 1945; and that I last saw h[illegible]m alive on 11-13 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 mos
Due to: Tuberculous laryngitis	3 weeks
Due to: Tuberculous enterocolitis	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Lee Finicane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4640

CERTIFICATE OF DEATH

11234 230

Reg. Dist. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince George

City or town: Berwyn (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rural & Main St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 21 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Berwyn Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1st & Main St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ellen Loretta Buscher

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Alexander F. Buscher

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28 - 1876

8. AGE:

Years	Months	Days	If less than one day
69	9	5	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Wm. P. McNally

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary A. Cook

15. Birthplace: Baltimore

16. Informant: Gertrude M. McNally

Address: 8710 - 49th Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1945 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore Md.

18. Funeral director: James D. Regan Inc.

Address: 3th - Pa. Ave. S.E. Wash. D.C.

19. 11/5 1945 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1937, to November 5 1945, and that I last saw h-- alive on November 5 1945

	DURATION
Immediate cause of death: Carcinoma of rectum	1yr.
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	10 yr.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert L. McLemore Jr M. D. or other

Address: 407 Main St Laurel Md. Date signed: 11/5/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1760

11235

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred: Old Brandywine Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Dorothy Butler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1933

8. AGE: Years 12 | Months 3 | Days 27 | If less than one day hrs. min.

9. Birthplace Upper Marlboro, Maryland (Town, county, and state)

10. Usual occupation School Girl

11. Industry or business

FATHER 12. Name William C. Butler

13. Birthplace Maryland

MOTHER 14. Maiden name Pauline C. Thompson

15. Birthplace Maryland

16. Informant William A. Butler

Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-45 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro Md.

18. Funeral director Pitcher Bros.

Address Upper Marlboro Md.

19. Nov 20 1945 F. H. Billingsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1945, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and shock	
Due to Fractured base of skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-19-45

Where did injury occur? Brandywine (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Old Brandywine Road

Means of injury Passenger in a car accident Injured at work?

Deputy medical Examiner

23. SIGNATURE [illegible] M. D. or other

Address Forestville Md Date signed 11-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9350)

CERTIFICATE OF DEATH

11236

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Seven years

Hospital, Institution, or street address where death occurred:
5503 - 43rd Avenue

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5503 - 43rd Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frank Robinson Calder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah DeGraf Calder

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 9 1851

8. AGE: Years	Months	Days	If less than one day
94	1	11	..... hrs. ..... min.

9. Birthplace: Fooshow China
(Town, county, and state)

10. Usual occupation: Machinist - Retired

11. Industry or business: U.S. Navy Yard

FATHER
12. Name: Rev. James K. Calder
13. Birthplace: Harrisburg Pa.

MOTHER
14. Maiden name: Ellen Winebrenner
15. Birthplace: Harrisburg Pa.

16. Informant: Mrs. Laura C. Stonebraker.
Address: 5503 - 43rd Ave, Hyattsville, Md.

17. (Burial, cremation, or removal. Which?) transportation
Date thereof: Nov 28, 1945 (month) (day) (year)

Cemetery or crematory: Harrisburg Cemetery

Location: Harrisburg Pa.

18. Funeral director: F. Gaschie sons.

Address: Hyattsville Md.

19. Nov 29" 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1945, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945, to Nov. 19 1945 and that I last saw him alive on November 19 1945

Immediate cause of death	DURATION
Arteriosclerosis	10 yrs. ?
Hypertension	1 yr ?
Due to: Myocarditis, chronic	1 yr ?
Due to: Senility	7 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wallace U. Mook M.D.
M. D. or other

Address: 905 Carroll Ave. Takoma Park 12, Md. Date signed 11-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 112231

1. PLACE OF DEATH:
County: Prince George County
City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince George's County Hospital.
How long in hospital or institution? 18 days-

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Branchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Russell William Carrell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1945

8. AGE: Years	Months	Days	If less than one day
		18	..... hrs. ..... min.

9. Birthplace: Prince George's County Hospital, Cheverly, Md
(Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name: William D. Hogan
13. Birthplace: Pa.

MOTHER
14. Maiden name: Lillian Carrell-
15. Birthplace: Pa.

16. Informant: Hospital Records
Address

17. Burial — Date thereof Nov 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Colmar Manor Md

18. Funeral director: F. Gaeta Sons
Address: Hyattsville Md

19. 11/10 1945 Amanda Dawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 1945 at 11 25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 27 1945 to Nov. 8 1945
and that I last saw h.i.m. alive on Nov. 8-1945

Immediate cause of death	DURATION
Prematurity 7 Mo.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John P. Clum M.D.
M. D. or other
Address: Hyattsville Date signed 11-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 11238

1. PLACE OF DEATH

County Prince George Registration Dist. No. 245

Village or City Mt Rainier No. 4033 - 34th St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME George E. Chapman If U. S. Veteran, specify WAR

(a) Residence: No. 4033 - 34th St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.

6. DATE OF BIRTH (month, day, and year) Aug. 15, 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Boston, Mass. (State or country)

FATHER

13. NAME ?

14. BIRTHPLACE (city or town) Mass. (State or country)

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) Mass. (State or country)

17. INFORMANT Albert W. Chapman (Address) 4033 - 34th St. Mt. Rainier

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ Burial Place Mt. Olivet Cemetery Date Nov. 14, 1945

19. UNDERTAKER William J. Malley (Address) 3200 - R.I. Ave. Mt. Rainier, Md.

20. FILED Nov 13, 1945 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 10 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw him alive on ..., 19...; death is said to have occurred on the date stated above, at ... m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Acute Congestive Heart Failure	Sudden

Other **Contributory Causes** of Importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) John D. Malone M. D.

(Address) Cheverly - Hyattsville

Acting Deputy Medical Examiner

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

11239

★ Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occurred:

Prince George General Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Geo.

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry N. Cook

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Sarah Elizabeth Cook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 3, 1872

8. AGE: Years	Months	Days	If less than one day
73	6		..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Richard Cook

13. Birthplace: England

MOTHER

14. Maiden name: Marie ?

15. Birthplace: Germany

16. Informant: Cook, Mrs. Richard (Son)

Address: 6003 Forest Rd, Cheverly, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 24/1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Rutland Rd. & D.C. line

18. Funeral director: Wm. J. Malley

Address: 8200 R.I. Ave. Mt. Rainier, Md.

19. 11/24/45 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1945 at 4 15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945, to Nov 22 1945.

and that I last saw h..... alive on Nov 21 1945

Immediate cause of death	DURATION
Cerebro-vascular Hemorrhage	
Due to: Cerebral Thrombosis	
Due to:	
Other conditions: Hypertension C.V. Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Brennan M. D. or other

Address: Prince Geo Gen Hospt Cheverly Date signed 11-22-45


RECEIVED
NOV 27 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11240

CERTIFICATE OF DEATH

★ Reg. Dist. No. 248

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Riverdale, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Leland Mem. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo. C
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6620 - R.D. Ave Calvert Homes
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frances Irene Cornett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 8 - 1944

8. AGE: Years	Months	Days	If less than one day
1	1	14	..... hrs. ..... min.

9. Birthplace: Providence Hosp. Wash. D.C.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Jack D. Cornett
13. Birthplace: Georgia
MOTHER 14. Maiden name: Virginia L. Gratz
15. Birthplace: Ohio
16. Informant: Myrtle I. Gratz G. mother
Address: 1114 Penn St. N.E. apt # 3
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-45 (month) (day) (year)
Cemetery or crematory: Arl. Natl Cemetery
Location: Ft Myer, Va
18. Funeral director: Lowe Chambers Co
Address: Riverdale, Maryland
19. Nov. 24 1945 James Devey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1945, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Shock	
Due to: Immersed burns body, legs, arms, face	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11-22-45
Where did injury occur? Calvert Hills P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Alcohol Explosion Injured at work? No
Deputy medical Examiner
23. SIGNATURE: James E. Boyd
M. D. or other
Address: Forestville Md Date signed 11-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

1241

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 242

Village or City District Heights No. 512 Ave E St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Judith Jean Cullen If U. S. Veteran, specify WAR ___

(a) Residence: No. 512 Ave E, District Hgts. St., ___ Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) August 26, 1940

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	5			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Wilmington (State or country) Delaware

FATHER

13. NAME Dale Chandler Cullen

14. BIRTHPLACE (city or town) Kent Squares (State or country) Pennsylvania

MOTHER

15. MAIDEN NAME Lillian Margaret Willard

16. BIRTHPLACE (city or town) Wilmington (State or country) Delaware

17. INFORMANT Mrs. Lillian Cullen (Address) 512 Ave E, District Hgts, Md.

18. BURIAL, ~~CREMATION OR REMOVAL~~ Place Cedar Hill Date 11-5-, 1945

19. UNDERTAKER W. W. Chambers Co. (Address) 517 H St SE

20. FILED 11/2, 1945 Thos D Griffith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 2 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from November 1, 1945, to November 2, 1945

I last saw h-er alive on Nov. 2, 1945; death is said to have occurred on the date stated above, at 6:00 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Rheumatic heart disease (mitral) with cerebral embolism	Feb 1945
	Nov 1 1945

Other **Contributory Causes** of importance:

Name of operation ___ Date of ___

What test confirmed diegnosis? ___ Was there an autopsy? ___

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) William Brannon M. D.

(Address) Capitol Heights, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

11/2/45 Coroner called + permission to sign certificate given
/s/ Bradbury, MD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

11242

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 12 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1905 - 14th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: ANNA E DAVIS

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Henry Davis

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): March 1, 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
25	8	3		

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Gov't. Clerk

11. Industry or business:

FATHER — 12. Name: Benjamin Richardson
13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Martha Christian
15. Birthplace: Lynchburg, Virginia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal to Date thereof 11 - 4 - 45 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location:

18. Funeral director: W Ernest Jarvis Co

Address: 1432 you St NW

19. Nov. 4, 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4, 1945 at 12.20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1945, to November 4, 1945 and that I last saw her alive on November 4, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 Mo 12 da
Due to: Laryngitis, tuberculous	1 Mo 2 da
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11243

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges County.

City or town Riverdale Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 days.

Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 56 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince

City or town Kensington.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 64 Lincoln Ave
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mr Remus Jerome Day.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Martha Jane Day

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 9, 1872

8. AGE: Years	Months	Days	If less than one day
73	6	17	...hrs. ...min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Gardener

11. Industry or business

FATHER 12. Name Dawson Day

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Cooley

15. Birthplace Maryland.

16. Informant pt's chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 28-1945 (month) (day) (year)

Cemetery or crematory Forest Oak, Gaithersburg md

Location Montgomery Co md

18. Funeral director Roy W. Barber

Address Laytonsville md

19. Nov 27 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1945 at 1 35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 1945 to Nov 25 1945

and that I last saw h... alive on Nov 25 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 yr.
Due to Senile arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE L. M. Mudd M.D.
M. D. or other

Address Riverdale Md Date signed Nov 26 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

11244

Reg. Dist. No. 237

1. PLACE OF DEATH:
County: Prince George
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Christorin Douglas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11/17/45

8. AGE: Years | Months | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Aquasco Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Robert Douglas
13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Thomas
15. Birthplace: Charles Co Md

16. Informant: Robert Douglas
Address: Aquasco Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30/45 (month) (day) (year)
Cemetery or crematory: Bryantown Cemetary
Location: Bryantown Md

18. Funeral director: A. J. Gunnes
Address: Aquasco Md

19. Nov 30th 1945 (Date rec'd by registrar) Mrs H. B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/29/45 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/17/45 19.. to 11/29/45 19.. and that I last saw h.. alive on 11/20/45 19..

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel A. D. Tabor M. D. or other
Address: Hughesville Date signed: 11/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11245

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 441 - 15th St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: MARIE EAGLESTON.

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edgar F. Eagleston
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): December 12, 1915

8. AGE: Years: 29 | Months: 10 | Days: 22 | If less than one day: ....hrs. ....min.

9. Birthplace: Louisville, Kentucky (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Crace
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Mary Hammond
15. Birthplace: Kentucky

16. Informant: Decedent
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: Neal Funeral Home By E. Neal
Address: 4812 Blagden N.W. Wash. D.C.
19. Nov. 3, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3rd 1945 at 6 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2nd 1945 to Nov 3rd 1945 and that I last saw her alive on Nov. 2nd 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	8 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md Date signed: 11/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

11246

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred: Home of Leonard H. Early
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Reeder Early

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1902

8. AGE: Years 42 | Months 11 | Days 24 | If less than one day ... hrs. ... min.

8. Birthplace Brandywine Md (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Railroad
FATHER 12. Name William W. Early
13. Birthplace Maryland
MOTHER 14. Maiden name Maria T. Reeder
15. Birthplace Maryland
16. Informant William W. Early
Address Brandywine Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-45 (month) (day) (year)
Cemetery or crematory All Faiths
Location Hyattsville, St. Mary's Co. Md.
18. Funeral director Tolson Bros.
Address Upper Marlboro Md.
19. Nov. 20 1945 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1945, at 1:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio Vascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner
23. SIGNATURE ... M. D., or other
Address Forestville Md. Date signed 11-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-E)

11247

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kenilworth Ave. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: George FINALL

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma E Finall

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 11. 1874

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: Va

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: George FINALL

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: EMMA E. FINALL

Address: Kenilworth Ave. N.E

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-24-45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg, Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. Nov. 23 19 45 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 19 45 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 45, to November 22 19 45 and that I last saw him alive on Nov. 20 19 45

Immediate cause of death	DURATION
Cancer of the Tongue	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben E. Stone M. D. or other

Address: 3417 Minnesota Ave. D.C. Date signed: 11/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

11248

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Potomac River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
Street No. On dredge in Potomac River
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chester Carrol Jules Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 17, 1911

8. AGE: Years	Months	Days	If less than one day
34			..... hrs. ..... min.

9. Birthplace Great Falls, Maryland (Town, county, and state)
10. Usual occupation Deck Hand
11. Industry or business Dredging Sand.
FATHER 12. Name Louis McComas Fisher
13. Birthplace Maryland
MOTHER 14. Maiden name Elizabeth Sullivan
15. Birthplace Maryland
16. Informant Mrs Margaret A. Dion
Address Route #3 Bethesda, Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 27, 1945 (month) (day) (year)
Cemetery or crematory Tom K. Dempsey Funeral Co
Location Bethesda Md
18. Funeral director F. Gaccia sons
Address Hyattsville Md
19. 11/26 19 45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 45 at 10 00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Asphyxia	
Due to (b) Drowning	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-26-45
Where did injury occur Potomac River Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Potomac River
Means of injury Fell off bridge Injured at work? Yes
Respectfully medical examiner
23. SIGNATURE ..... M. D. or other
Address Forestville Md Date signed 11-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1124 242

Reg. Diat. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Clinton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edna Mae Fogle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Samuel Fogle
~~April 21 1888~~ 6.(c) If alive, give age years
7. Date of birth (mo., day, yr.) April 21, 1888

8. AGE: Years 57 | Months | Days | If less than one day hrs. min.

9. Birthplace Brentsville Va (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Robert A. Cooper
13. Birthplace Brentsville Va

MOTHER
14. Maiden name Marion Woodyard
15. Birthplace Buckhall Va

16. Informant Mr Samuel Fogle
Address Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1945 (month) (day) (year)
Cemetery or ~~cemetery~~ Valley View Cem.
Location ~~Washington D.C.~~ Nokesville, Va.

18. Funeral director J. Frank Joy
Address 500 E. St. N.E.

19. 11-30 19 45 Thos. D. Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1945, at 12:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to Nov 30 1945
and that I last saw her alive on Nov 29 1945

Immediate cause of death	DURATION
Carcinomas of body of uterus with metastasis	about 1 yr
Due to —	
Due to —	
Other conditions Secondary Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul C. Van Natta M. D. or other
Address Washington D.C. Date signed 12/3 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11250

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: ARDMORE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MONTHS
Hospital, Institution, or street address where death occurred: EDNA MARINE NURSING HOME
How long in hospital or institution? 4 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: PRI. GEO.
City or town: COLLEGE PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4613 DREXEL ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: AUREL OVERTON FOSTER, JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAY 6, 1943.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
2				

9. Birthplace: WASHINGTON, D. C.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER — 12. Name: AURE OVERTON FOSTER, SR.
13. Birthplace: MARATHON, NEW YORK

MOTHER — 14. Maiden name: MARGARET BRUCE LINKLATER
15. Birthplace: NEW YORK CITY.

16. Informant: AUREL O. FOSTER, SR
Address: 4613 DREXEL RD. COLLEGE PK, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV. 15, 1945 (month) (day) (year)
Cemetery or crematory: FORT LINCOLN CEM.
Location: COLMAR MANOR, MD

18. Funeral director: G. Gaschis Sons
Address: HYATTSVILLE, MD.

19. 11/15 1945 (Date rec'd by registrar) Amanda Dauney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV 13 1945 at 5:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1945 to NOV 13 1945 and that I last saw h.i.m. alive on NOV - 13 1945

Immediate cause of death	DURATION
Marasmus	1 yr.
Due to: Cause unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: John J. Maloney M. D. or other
Address: Calverly, Hyattsville, Md. Date signed: 11-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Prince George's Gen. Hospt.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Prince Geo. Apartments
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Furry Mrs. Katherine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1859

8. AGE: Years: 86 Months: 1 Days: 12 If less than one day: hrs. min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Smith, Amos
13. Birthplace: New York

MOTHER
14. Maiden name: Curry, Eunice
15. Birthplace: New York

16. Informant: Furry, Miss Margaret (daughter)
Address: Prince Geo. Apts. Hyattsville, Md

17. Ship by train (Burial, cremation, or removal. Which?) Date thereof: 11-14-45 (month) (day) (year)
Cemetery or crematory: Alden, Iowa
Location:

18. Funeral director: W W Chambers Co
Address: Riverdale, Md

19. 11/14 19 45 Amanda Dewey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 19 45 at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 19 45 to Nov. 14 19 45
and that I last saw h[illegible] alive on Nov. 9 19 45

Immediate cause of death	DURATION
Fractured neck of left femur	
Due to: Fall	
Due to:	
Other conditions: Hypertensive cardiovascular disease with hypertensive degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville, Md. Date signed: 11-14-45

11252

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 275

1. PLACE OF DEATH:
County Prince Georges
3918 Allison St.
City or town N. Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
3918 Allison
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr. Geo
City or town N. Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3918 Allison St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Herbert Charles Galloway

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Lucy Galloway
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace Wash. DC (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business U. S. Government

FATHER
12. Name Joseph Galloway
13. Birthplace Unknown

MOTHER
14. Maiden name Rachel B. Harris
15. Birthplace Unknown

16. Informant Arthur E. Thomas
Address 10110 E. Westchester Ave Glenarden

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 18 1945 (month) (day) (year)
Cemetery or crematory M.T. Rodgers
Location Bladensburg Md
18. Funeral director Magalis Bros
Address Bladensburg md

19. Nov 18 1945 (Date rec'd by registrar) James Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 19 45 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac failure	unknown
Due to Cardio-vascular heart disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John W Maloney acting County medical examiner
M. D. or other
Address Hyattsville, md Date signed 11-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11253

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 242

1 PLACE OF DEATH
County Prince George

Village or City Fairmont Hgts (No. 906 Addison Rd St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alberta S. Gardiner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
F	Negro	

6 DATE OF BIRTH
10 - 29 (Month) (Day), 1891 (Year)

7 AGE
54 yrs. 1 mos. ds. | If LESS than 1 day hrs. or min.

8 OCCUPATION
(a) Trade, profession or particular kind of work Cost Employee
(b) General nature of industry business, or establishment in which employed or (employer) Chimnuk.

9 BIRTHPLACE (State or country) Prince George Cty Md

PARENTS

10 NAME OF FATHER John T. Gardiner

11 BIRTHPLACE OF FATHER (State or country) Prince George Cty Md

12 MAIDEN NAME OF MOTHER Emma Olivia Scott

13 BIRTHPLACE OF MOTHER (State or country) Prince George Cty Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Cornelia E. Stewart

15 Filed 11-12 1945 Carrie F. Campbell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
11 - 11 (Month) (Day), 1945 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1942 to 11 - 11, 1945 that I last saw h e r alive on 11 - 10, 1945 and that death occured on the date stated above, at 12 30 P m.

The CAUSE OF DEATH * was as follows:
Coronary Occlusion

Immediate (Duration) yrs. mos. ds.

Contributory Secondary Essential Hypertension (Duration) 3 yrs. mos. ds.

(Signed) Alvin Thurston M. D.

11 - 11 1945 (Address) 4932 Bennings Rd N.E.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ridgley, md DATE OF BURIAL Nov. 14, 1945

20 UNDERTAKER John T. Stewart ADDRESS 30 H St N.E.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

N. B.--Every item of information should be carefully supplied ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT

MARGIN RESERVED FOR BINDING

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-2)

CERTIFICATE OF DEATH

11254

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges ~~Coop~~.
City or town Chevrely, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 hrs. 50 min.
Hospital, institution, or street address where death occurred:
Prince Georges Hosp.
How long in hospital or institution? 11 hrs. 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town cottage city
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4300 Bladensburg Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Norman Giaquinto

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) aug. 13, 1925

8. AGE: Years	Months	Days	If less than one day
20	3	13	..... hrs. ..... min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business

FATHER
12. Name attilio Giaquinto
13. Birthplace Italy

MOTHER
14. Maiden name martha Christiansen
15. Birthplace Norway

16. Informant attilio Giaquinto
Address 4300 Baltimore Cottage City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29, 1945 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Washington D.C.

18. Funeral director F Geschis Sons
Address Hyattsville Md.

19. 11/28/45 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1945, at 8 50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Cerebral Compression	
Intra cranial hemorrhage	
Due to fracture of base of skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-26-45
Where did injury occur? Cottage City (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fell down stairs Injured at work? No

Deputy Medical Examiner
23. SIGNATURE James J. Bond, M. D. or other
Address Forestville Md. Date signed 11-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

11255

S.S. # 578-03-8240.

1. PLACE OF DEATH

County: Prince Georges (926) Registration Dist. No. 2140

Village or City: Brandywine Dist No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William Roy Greer

(a) Residence: No. Brandywine Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	white	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) May 8th 1883

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked, at this occupation (month and year) April 11. Total time (years) spent in this occupation 40 yrs

12. BIRTHPLACE (city or town) Cedarville (State or country) Md

FATHER

13. NAME William J Greer

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Emily Watson

16. BIRTHPLACE (city or town) Prince Geo Co (State or country) Maryland

17. INFORMANT Fielder C. Greer (Address) Brandywine Md

18. BURIAL, CREMATION, OR REMOVAL Place Rockledge Md Date 11/17, 1945

19. UNDERTAKER Fielder Brothers Inc (Address) Upper Marlboro Md.

20. FILED Nov. 16, 1945 F. H. Bellingsley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov. (Month) 15 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1944, to Nov 15, 1945

I last saw him alive on Nov. 14, 1945; death is said to have occurred on the dete stated above, at 8:20 P. M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Mitral Stenosis	6 yrs
Other Contributory Causes of Importance: Endocarditis & Rheumatic Fever	40 yrs

Name of operation Date of

Whet test confirmed diagnosis? Was there an autopsy?

23. If death was due to externat causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John E. Powers M. D.

(Address) Brandywine Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11256

Reg. Dist. No. 245

1. PLACE OF DEATH: ~~PRINCE~~ GEORGE County

City or town Hyattesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mother Jones Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4830- Illinois Ave N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jeannette M. Griffith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James E. Griffith

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 23, 1877

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Thomas King
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Muir
19. Birthplace: Virginia

16. Informant: Mr James E. Griffith (Husband)

Address: 4830- Ill Ave N.W. Wash, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6 1945 (month) (day) (year)

Cemetery or crematory: Glenwood Cem Nov 6, 1945

Location: Washington D.C.

18. Funeral director: The S. Hines Co Washington D.C.

Address: 2901-14-st N.W.

19. Nov 4 1945 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1945, at 330 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1945 to November 3 1945

and that I last saw h[illegible] alive on November 2 1945

	DURATION
Immediate cause of death: Uremia Myocarditis	Several years
Due to: Arteriosclerosis	Several years
Other conditions: Senility	Several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Mr. Ellen Griffith M. D. or other

Address: Berwyn Md Date signed 11/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

11257

Reg. Dist. No. 232

1. PLACE OF DEATH:
County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margaret Priscilla Griffith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife James A. Griffith
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 11-1890.

8. AGE: Years 54 | Months 11 | Days 1 | If less than one day hrs. min.

9. Birthplace Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation At home.

11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Charles County, Md.

MOTHER
14. Maiden name Elizabeth Wood
15. Birthplace Upper Marlboro, Md.

16. Informant James A. Griffith
Address Upper Marlboro, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Nov 14-45
(month) (day) (year)
Cemetery or crematory Union Methodist
Location Upper Marlboro, Md.

18. Funeral director Pitchie Brothers
Address Upper Marlboro, Md.

19. Nov 14 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945, at 1:55 A. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 1 1945 to Nov 12 1945 and that I last saw her alive on Nov 12 1945

Immediate cause of death	DURATION
Congestive Heart Failure	6 hrs
Due to Hypertension	4 yrs
Due to Nephritis	6 yrs
Other conditions Obesity	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James E. Tasseer M. D. or other
Address Upper Marlboro Md. Date signed 11-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15


RECEIVED
NOV 15 1995

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-T)

CERTIFICATE OF DEATH

11258

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
Prince Geo. General Hospt.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince Geo.

City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3713-37th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grass Mrs. Leona

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife George Grass

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1900

8. AGE:

Years	Months	Days	If less than one day
45	7	5	..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Worker

11. Industry or business

FATHER
12. Name John Elkins
13. Birthplace Va.

MOTHER
14. Maiden name Lilly West
15. Birthplace Va.

16. Informant Mrs. Ella Jones (daughter)
Address 3713-37th Ave. Cottage City, Md.

17. Burtrain (Burial, cremation, or removal. Which?) Date thereof 11-24-45 (month) (day) (year)

Cemetery or crematory Richlands Cemetery

Location Richlands, Va

18. Funeral director W W Chandler & Co

Address Riverdale Md.

19. 11/21/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 19 45, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 19 45 to Nov 20 19 45
and that I last saw h. alive on Nov 19 19 45

Immediate cause of death	DURATION
Acute bronchopneumonitis	
Due to Streptococcus	
Due to	
Other conditions Influenza	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John W Downey M. D. or other

Address Prince Geo Hosp Date signed 11-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-d)

CERTIFICATE OF DEATH

★ 11252 39 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington, D.C. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 485- G. St. S.W. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Alton Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 2/44.

8. AGE: Years	Months	Days	If less than one day
	11		hrs. min.

9. Birthplace: Washington, D.C.
(town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER 12. Name: Alton Harris
FATHER 13. Birthplace: Alexandria, Va

MOTHER 14. Maiden name: Peggy Harris
MOTHER 15. Birthplace: Culleppper, Va.

16. Informant: Mary R. Davis
Address: 190- Washington Blvd.

17. Removal (Burial, cremation, or removal? Which?) Date thereof: Nov 1-1945 (month) (day) (year)
Cemetery or crematory: G Wash. DC
Location:

18. Funeral director: Harold J. Taltavull
Address: 436-7th St. S.W. Wash, D.C.

19. Nov 1 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 19 45, at 7 55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Nov 1 1945, and that I last saw h... alive on Oct 31 1945.

Immediate cause of death: Convulsions — DURATION
Cerebral abscess
Due to: Mixed infections
Cerebral hemorrhage
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Goodson M.D.
M. D. or other
Address: Warren St Hosp Date signed: Nov 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11260

Reg. Dist. No. 240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cedarville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cedarville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Agnes Cecilia Herd

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

8.(b) Name of husband or wife: Albert Herd

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): Sept 2, 1924

8. AGE: Years: 21 | Months: 2 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: William Graham

13. Birthplace: Maryland

MOTHER

14. Maiden name: Frances Alice Cooper

15. Birthplace: Maryland

16. Informant: Roberta Birdsong

Address: Cedarville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-12-45 (month) (day) (year)

Cemetery or crematory: St Peters

Location: Waldorf Md

19. Funeral director: Hunt & Ryon

Address: Waldorf md

19. 11-10- 19 45 (Date rec'd by registrar) F. V. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 19 45 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Toxemia	
Exhaustion	
Due to: Pulmonary tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner James J. Boyd M. D. or other

Address: Forestville Md Date signed 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

11261

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Mitchellville - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: ~
How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mitchellvill - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Milton Le Roy Hopkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Thelma R. Hopkins
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): June 5 1893

8. AGE: Years: 52 Months: 5 Days: 25 If less than one day: ...hrs. ...min.

9. Birthplace: Hall - Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Same

FATHER — 12. Name: Henry Clay Hopkins
FATHER — 13. Birthplace: Bristol, Md.

MOTHER — 14. Maiden name: Ella Izora Crook
MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Mrs Thelma Hopkins
Address: Mitchellville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 2, 1945 (month) (day) (year)
Cemetery or crematory: Mt Oak
Location: Mitchellville Md.

18. Funeral director: F. Gaschè Sons.
Address: Hyattsville Md.

19. 12-1-45 19... (Date rec'd by registrar) Louise H Read Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1945, at 11:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943, to Nov 30 1945 and that I last saw him alive on Nov. 30 1945

Immediate cause of death	DURATION
Chronic Lymphatic Leukemia	2 yrs
Due to	
Due to	
Other conditions: Secondary Anemia	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op. ~

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James C. Saucer M. D. or other
Address: Upper Marlboro, Md Date signed 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

11262

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince Ge.
City or town Laurel - Brookly Beach P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State West Virginia County
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph William Howell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male.	White	Widowed

6.(b) Name of husband or wife Louise Hall (Mrs.)
deceased - 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1868

8. AGE:

Years	Months	Days	If less than one day
77	6	15	...hrs. ...min.

9. Birthplace Charlestown W. Va.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Joseph Dr Howell -
13. Birthplace W. Va.
MOTHER 14. Maiden name Nat Lemon -
15. Birthplace W. Va
16. Informant Daughter Mrs Wilbert Kaiser
Address Laurel Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15-45 (month) (day) (year)
Cemetery or crematory Charlestown W. Va
Location " "
18. Funeral director Lloyd Kaiser
Address Laurel Md
19. Nov 13 1945 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11th 1945, at 4-30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1- 1945, to Nov 11 1945
and that I last saw h...alive on Nov 1 1945

Immediate cause of death	DURATION
(a) Cor. Coronac Dilatation	
Due to (b) Cerebral Hemorrhage	
Due to (c)	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. P. Warren M. D. or other
Address Laurel Md Date signed 11-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Diat. No. 11263

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Geo's.

City or town: Blod Ayto.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Geo.

City or town: Blod Ayto

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4807 - Ellis ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK - HRBEK JR

3.(b) Social Security Number: 579-03-7192

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 18 12

8. AGE: Years: 32 | Months: 11 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Bata Md (Town, county, and state)

10. Usual occupation: Laborer Iron

11. Industry or business:

FATHER — 12. Name: Frank Hrbek

13. Birthplace: Czechoslovakia

MOTHER — 14. Maiden name: Frances Bednarik

15. Birthplace: Czechoslovakia

16. Informant: Frank Hrbek Jr

Address: 1473 - 72 ave Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-17-45 (month) (day) (year.)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: C. A. Chambers

Address: 517-11 St S.E.

19. Nov. 15 1945 (Date rec'd by registrar) Irene A. Bowser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14th 1945 at 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7th 1945, to Nov 14 1945

and that I last saw him alive on November 7th 1945

Immediate cause of death	DURATION
Coronary Occlusion	Hr Minutes
Due to: Narrowed Lumen of Coronary Arteries	Unknown
Due to:	
Other conditions: Acute Bronchitis	6 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur N. Meloy M. D. or other

Address: 4400 Bowie Rd LC Date signed: 11-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11264

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 11 mos., 21 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr 11 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1015 - 3rd St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: ERNEST LEON JOHNSON

3.(b) Social Security Number: 578-18-3906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 5, 1920

8. AGE: Years	Months	Days	If less than one day
25	–	–	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Guard
11. Industry or business:

FATHER
12. Name: Ernest Johnson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Margarette Ware
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/6/45 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Eugene Ford
Address: 1300 Southcapitol st SE

19. Nov-5, 1945 (Date rec'd by registrar) Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-5-1945 at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-15-1943 to 11-5-1945
and that I last saw h.. alive on 11-4-1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs 9 mo.
Due to: Tuberculous empyema, left	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11265

★ Reg. Dist. No. 2462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: D. C.

City or town: Washington Precinct

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

Newport Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: D. C.

City or town: Newport Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Newport Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Annie Catherine Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W

6.(b) Name of husband or wife: Richard Jones

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 5, 1850

8. AGE: Years: 95 | Months: 3 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pa

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: .....

13. Birthplace: .....

MOTHER — 14. Maiden name: .....

15. Birthplace: .....

16. Informant: Mrs. Madeline Jones

Address: 1504 Newport Ave N.E. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27 1945 (month) (day) (year)

Cemetery or crematory: Soldier's Cemetery

Location: Washington, D. C.

18. Funeral director: J. B. Johnson

Address: Washington D.C.

19. ..... 19..... (Date rec'd by registrar) Irene A. Connie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 19 45 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial Hemorrhage	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: Deputy medical Examiner James G Bond M. D. or other

Address: Forestville Md. Date signed 11-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

11266 Reg. Dist. No. 234

1. PLACE OF DEATH:
County Prince George
City or town Fort Foote Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7805 Open Hill Rd. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Buchanan Kerby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wht.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 1856

8. AGE: Years	Months	Days	If less than one day
89		25	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Wm Kerby
13. Birthplace Md.

MOTHER
14. Maiden name Barbara Deisender
15. Birthplace Md.

16. Informant Barbara Webster
Address 7805 Open Hill Rd. S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20 1945 (month) (day) (year)
Cemetery or crematory St Johns Episcopal
Location Broad Creek, Prince George Co Md
18. Funeral director Thomas F Murray
Address 2007 Nichols Ave S.E. Washington D.C.

19. Nov. 19 1945 (Date rec'd by registrar) Edward J Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1937, to Nov. 17 1945
and that I last saw him alive on Nov. 15 1945

Immediate cause of death	DURATION
cerebral Hemorrhage	
Due to gen arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Schuetzman M. D. or other
Address 2015 Nichols St. Date signed 11/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-3)

CERTIFICATE OF DEATH

11267 ★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George County
City or town: Rural, Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: Mother Jones Rest Home
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125- Barto Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lucie Everett King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28, 1861

8. AGE: Years: 84 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Dr. John Everett
13. Birthplace: Mass. Dilley

MOTHER
14. Maiden name: Armida Elizabeth
15. Birthplace: Cumberland Md.

16. Informant: Lillie May Burgess
Address: Riggs Rd. Hyattsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 11-14-45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland Md.

18. Funeral director: J. Arthur Walters
Address: 254 Carroll St. D.C.

19. Nov 14 (Date rec'd by registrar) 1945 James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to November 14 1945 and that I last saw her alive on November 3 1945

Immediate cause of death	DURATION
Chronic myocarditis	Several years
Due to Senility	Several years
Due to Arteriosclerosis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Wm. Allen Griffiths M. D. or other
Address: Berwyn Md. November 14 Date signed:

Evidence for the change of age is shown on

11268

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

Reg. Dist. No.

G 99 11-30-45

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4706 Sheridan St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ferdinand J. Klaus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lydia Klaus

7. Birth date of deceased (mo., day, yr.): Dec 3, 1880 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
64	11	14	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Mfg

11. Industry or business

FATHER 12. Name: Albert Klaus

13. Birthplace: Germany

MOTHER 14. Maiden name: Caroline

15. Birthplace: Germany

16. Informant: Lydia Klaus

Address: 4706 Sheridan St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21/45 (month) (day) (year)

Cemetery or crematory: Baltimore Cem

Location: Baltimore Md

18. Funeral director: Philip Sherwin Sons

Address: 2024 Orleans St

19. 11-20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19/45 19 at 4 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 45, to Nov 19 19 45

and that I last saw h alive on Nov. 19 19 45

Immediate cause of death	DURATION
Coronary of	
Due to Pyelitis and Chronic	
Stomach Ulcer	
Due to Metastases to	
Liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Klaus M. D. or other

Address: Hyattsville Md Date signed 11-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

4314 Gallatin

11269

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bradbury Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md County: Prince Geo
City or town: Bradbury Hgts
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5305 - 7 St NE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE W. KNOTT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mamie Knott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 17 92

8. AGE: Years: 53 Months: Days: If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Samuel Knott
13. Birthplace: Md

MOTHER
14. Maiden name: Jennie Campbell
15. Birthplace: Leesburg, Loudoun Co, Va.

16. Informant: Mamie Knott
Address: 5305 - 7 St SE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/45 (month) (day) (year)
Cemetery or crematory: Washington Natl
Location: Suitland Md.

18. Funeral director: W. D. Chambers Co
Address: 517 - 11th St - S.E.

19. 11/19/45 (Date rec'd by registrar) Irene A Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1945, to Nov 19 1945 and that I last saw h... alive on Nov 19 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 hrs
Due to: arteriosclerosis	unknown
Due to: Hypertensive cardiac disease	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry G Hadley M. D. or other
Address: 1252 6th St NW Date signed: Nov 19 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11279

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 711 - P. Street N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3. (a) FULL NAME: AhMA. LAWSON

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 13, 1915

8. AGE: Years	Months	Days	If less than one day
29	10	26	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Cafeteria Employee
11. Industry or business:
FATHER 12. Name: Joseph Lawson
13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Chesley Lawson
15. Birthplace: Washington, D. C.
16. Informant: Chesley Martin - Mother
Address: 511 Lamont St. N. W.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 9 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D. C.
18. Funeral director: Barron Bro.
Address: 48-K 8th. E. Wash. 2. D C
19. Nov. 8 1945 (Date rec'd by registrar) Rowland S. Pilibjas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1945, at 6.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Nov 8 1945 and that I last saw h. alive on November 8 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

1127 245

Reg. Dist. No.

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Riverdale md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co.
City or town: Berwyn Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war: — no —

3.(a) FULL NAME: Olivia Baker Leaman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary K. Leaman
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 22. 1874.

8. AGE: Years	Months	Days	If less than one day
71	0	23	hrs. min.

9. Birthplace: Germantown Md
(Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business:
12. FATHER — Name: Geo W. Leaman
13. FATHER — Birthplace: Md
14. MOTHER — Maiden name: Martha E Motz.
15. MOTHER — Birthplace: Md
16. Informant: Margaret L. Lynn
Address: 320 N. Oxford st Arlington Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 19, 1945 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: Washington D.C.
18. Funeral director: F Waschs sons
Address: Hyattsville Md.
19. Nov 19 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1945 at 11 55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Exhaustion	
Due to: Cerebral Compression	
Due to: Extra Cranial Hemorrhage extensive subarachnoid	
Other conditions: and petechial Cerebral in Lept	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 11-4-45
Where did injury occur? Beltsville P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner
M. D. or other
Address: Forestville md Date signed: 11-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11272

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges'

City or town: Glenn Dale, Maryland - RURAL
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 14 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium, of the D.C.

How long in hospital or institution? 4 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1451- Church St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Katie Lewis

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	widowed

6.(b) Name of husband or wife: Henry W. Lewis

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 25, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	11	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business: —

FATHER — 12. Name: Robert W. Creek

FATHER — 13. Birthplace: Prince Geo. Co., Md.

MOTHER — 14. Maiden name: Rachel McCiney

MOTHER — 15. Birthplace: Arundel Co., Md.

16. Informant: decedent

Address:

17. Removal (Burial, cremation, or removal, Which?) Date thereof Nov. 5 1945 (month) (day) (year)

Cemetery or crematory: Wash., D. C.

Location:

18. Funeral director: W. Ernest Jarvis Co, 1432 U St. N.W.

Address: JARVIS 1432 NO

19. Nov. 5 1945 Rowland S Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-5 1945 at 5 45/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1945, to 11-4 1945; and that I last saw her alive on 11-4 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	4½ mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md Date signed: 11-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

CERTIFICATE OF DEATH

11273

Reg. Dist. No. 230

1. PLACE OF DEATH:
County Prince George
City or town Berwyn, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Enroute to Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. Geo
City or town Berwyn
(If outside city or towo limits, write RURAL aod give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jesse ~~Gilbert~~ Delbert Lovejoy

3. (b) Social Security Number

4. Sex M.
5. Color or race W.
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Irene Lovejoy
6.(c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) Nov. 8, 1919.

8. AGE: Years 26 Months Days 5 If less than one day ..... hrs. ..... min.

9. Birthplace Detroit, Mich.
(Town, county, and state)
10. Usual occupation Service Station Attendant
11. Industry or business Gasoline Station

FATHER
12. Name Jesse Lovejoy
13. Birthplace Indiana.

MOTHER
14. Maiden name Gertrude Timmons
15. Birthplace Indiana.

16. Informant Irene Lovejoy
Address 5610 - Cunningham Drive

17. transportation Date thereof 11-15-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dearborn Michigan
Location Dear Born Michigan
18. Funeral director F. Gasch's Sons
Address Hyattsville Md.

19. 11/15 1945 Amanda Dauney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945, at 5-20 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h..... alive on ..... 19...

Immediate cause of death Shock — DURATION: Sudden
Due to Electrocution
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Nov. 13, 1945
Where did injury occur? Berwyn, Pr. Geo. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Highway
Means of injury High tension wires Injured at work? Vol. fireman

23. SIGNATURE John D. Maloney acting deputy medical Examiner
M. D. ~~or other~~
Address Hyattsville, Md Date signed 11-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11274

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince Georges

City or town Mueahich (If outside city or town limits; write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Route #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State District of Columbia County

City or town Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1110 Browning Place N.E. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carlton Lowe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	seperated

8.(b) Name of husband or wife Ora Barnes Lowe

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1900.

8. AGE:

Years	Months	Days	If less than one day
45	5	0	..... hrs. ..... min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation Cement Finisher

11. Industry or business

FATHER 12. Name Lonnie Lowe.

13. Birthplace Georgia.

MOTHER 14. Maiden name Lula Ash

15. Birthplace Georgia

16. Informant William Lowe

Address 606 R st N. W Washington D.C.

17. Removal Date thereof Nov 10. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory R.N. Horton Funeral Home Washington

Location 1322 You st N. W DC

18. Funeral director I Gasch's sons

Address Hyattsville Md

19. Nov. 10 1945 (Date rec'd by registrar) James Severs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed skull	
Crushed chest	
Due to Crushed legs leg	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-10-45

Where did injury occur? Mueahich P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury Hurled on auto collision Injured at work? No

23. SIGNATURE: Deputy medical Examiner James J. Lord M. D. or other

Address Forestville Md Date signed 11-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11275 231

Reg. Dist. No. ~~229~~ 1

1. PLACE OF DEATH:

County: Prince George County

City or town: Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 337 Prince George St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Titus Watson Lusk

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Aurilla May Lusk.

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Oct. 10-1872.

8. AGE:

Years	Months	Days	If less than one day
73	1	20	....hrs. ....min.

9. Birthplace: Dutring, West Virginia (Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business

FATHER 12. Name: William Lusk

FATHER 13. Birthplace: Princeton, West Virginia

MOTHER 14. Maiden name: Mary Jane Hurst.

MOTHER 15. Birthplace: Princeton, West Virginia

16. Informant: Thomas Lusk - 4220 Kenilworth Gaithersville Md-

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 3-45 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: Lloyd Kaiser

Address: Laurel Md.

19. December 3 19 45 Cora E. Wachter Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1945, at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1945, to Nov 30 1945. and that I last saw him alive on Nov. 30 1945

	DURATION
Immediate cause of death: Chronic Glomerular Nephritis	4 yrs.
Due to:	
Due to: Arteriosclerosis	10 yrs.
Other conditions: Secondary Anemia	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Janicen M. D. or other

Address: Upper Marlboro Md Date signed 11-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

3309 Fairmount St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11276245
Reg. Diat. No.

1. PLACE OF DEATH:
County Prince George
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rugby Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie Marowski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1850

8. AGE:	Years	Months	Days	If less than one day
	95	8	1	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Records of Mother Jones Rest Home
Address Cheltenham, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21 - 1945 (month) (day) (year)
Cemetery ~~or crematory~~ Evergreen
Location River Road Bladensburg-Md
18. Funeral director Adams & Pumphrey.
Address 6434 Ga Ave. Silver Spring. Md.

19. Nov 20 1945 James Beery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Uremia	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work

23. SIGNATURE Deputy medical examiner
James A. Long
M. D. or other
Address Forestville Md Date signed 11-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-E

CERTIFICATE OF DEATH

11277

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos., 12 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 4 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1307 Wallach Place, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: BENJAMIN H. MILES

3.(b) Social Security Number: 579-07-8777

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 22, 1914

8. AGE:

Years	Months	Days	If less than one day
31	1	—	hrs. min.

9. Birthplace: Saluda, South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: George Miles

13. Birthplace: Saluda, South Carolina

MOTHER

14. Maiden name: Sophie Young

15. Birthplace: Saluda, South Carolina

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal: Which?) Date thereof: Nov. 22, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Crown Funeral Home

Address: 608 K St. N.W.

19. Nov. 22, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22, 1945, at 7:½ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1944, to Nov 22, 1945 and that I last saw h... alive on Nov. 21, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 yr 7 mo.
Due to:	
Due to: Right tuberculous empyema	9½ mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

11278

Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos., 9 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1809 Rosedale St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: JEAN GLORIA MITCHELL.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26, 1930

8. AGE: Years	Months	Days	If less than one day
15	7	8	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: (Child)
11. Industry or business:

FATHER
12. Name: Octavius P. Mitchell
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Marie Carter
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Nov. 3 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.
18. Funeral director: Magee Funeral Home
Address: 389 R. I. Ave. N.W.

19. Nov. 3 1945 (Date rec'd by registrar) Rowland L. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3rd 1945, at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25th 1945, to Nov. 3rd 1945, and that I last saw her alive on Nov. 3rd 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale Md. Date signed: 11/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

11279

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred:
4305 - Eastern Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4305 - Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louis Wesley Mona

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myrtle Louise Mona
6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): February 17, 1911

8. AGE:

Years	Months	Days	If less than one day
34	9	11	hrs. / min.

9. Birthplace: Pawtucket, R.I.
(Town, county, and state)

10. Usual occupation: Clerk
11. Industry or business: Engineers Research Corp

FATHER
12. Name: Elias Mona
13. Birthplace: Syria

MOTHER
14. Maiden name: Johnson
15. Birthplace: Syria

16. Informant: John T. Greene
Address: 4307 Russell Rd Mt Rainier

17. Burial, cremation, or removal. Which?: Removal by train
Date thereof: 11-19-45 (month) (day) (year)
Cemetery or crematory: Pawtucket Cemetery
Location: Pawtucket R.I.

18. Funeral director: D W Chambers Co
Address: Riverdale, Md

19. Nov 19" 1945 (Date rec'd by registrar) James Beers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1945 at 11 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy medical Examiner
23. SIGNATURE: James J. Boyd M. D. or other
Address: Forestville Md Date signed: 11-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9320)

CERTIFICATE OF DEATH

11281

Reg. Dist. No. 237

1. PLACE OF DEATH:
County: Prince Georges
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: CHARLES D MONTGOMERY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Julia Wilkerson Montgomery
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): July 5 1876

8. AGE:

Years	Months	Days	If less than one day
70	5	11	...hrs. ...min.

9. Birthplace: Charles Co Md
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: mercantile business

FATHER
12. Name: Marcellus Montgomery
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: Alice Davis
15. Birthplace: Charles Co. Md

16. Informant: mrs Julia Montgomery
Address: Aquasco Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-19-45 (month) (day) (year)
Cemetery or crematory: St Peters Cemetery
Location: Waldorf, Md

18. Funeral director: Elmer M Wade
Address: Hughesville, Md

19. Nov 17th 1945 (Date rec'd by registrar) Mrs Emory B Carter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/15/45 19.. to 11/16/45 19.. and that I last saw him alive on 11/13/45 19..

Immediate cause of death	DURATION
Arterial Hypertension	Not Given
Due to: Hypertensive Heart Disease	8 Yrs
Due to: Cardiac Decompensation	3 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel A Tucker M. D. or other
Address: Hughesville Date signed: 11/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 11281

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Contee Road, Laurel, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Contee Road Beaverdam Dist.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Homer Montgomery

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary MacLean Montgomery

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): June 4 - 1886

8. AGE: Years	Months	Days	If less than one day
59	5	19	....hrs. ....min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Geo. H. Montgomery

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Ellen M. Morgan

15. Birthplace: West Virginia

16. Informant: Mrs. Mary M. Montgomery

Address: Contee Road Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov-26-1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: D. District, Prince

18. Funeral director: Lloyd Kausel

Address: Laurel, Maryland.

19. November 26 1945 (Date rec'd by registrar) Carl E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1945, at 12 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/23/45 19.... to 11/23/45 19.... and that I last saw h... alive on 11/23/45 19....

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to —	
Due to	
Other conditions: Bilat. Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J M Warren M D

M. D. or other

Address: Laurel Md. Date signed 11/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

11282

Reg. Dist. No. 242

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Georges

City or town: Capital Heights Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months.

Hospital, institution, or street address where death occurred:
4401 - Walbrook Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capital Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4401 - Walbrook Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alberta Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	(illegible)

6.(b) Name of husband or wife: Robt. Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 11 1895

8. AGE: (50) 50 | Years | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pr. Geo. Co. Md.
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: Laundry

FATHER
12. Name: Lambert Tolson
13. Birthplace: Md.

MOTHER
14. Maiden name: Isabel Jackson
15. Birthplace: Md.

16. Informant: Mrs. Jackson
Address: 4401 - Walbrook Mill Rd.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 12-45
(month) (day) (year)

Cemetery or crematory: Payne's Cemetery

Location: Washington D.C.

19. Funeral director: J. T. Johnson

Address: Capitol Hts.

19. Nov. 10 19 45 (Date rec'd by registrar) Irene A. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 19 45 at 11:00 AM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 45 to Nov 7 19 45 and that I last saw her alive on Nov. 7 19 45

Immediate cause of death	DURATION
Cerebral Haemorrhage	?
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. G. Bellows M. D., or other

Address: 4423 - Hunt Pl. NE Date signed: 11-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11283

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: WITHIN CORPORATE LIMITS

County: Prince Geo. Co.

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~11 days~~ 32 days

Hospital, institution, or street address where death occurred: Warren Hospital

How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince Geo. Co.

City or town: Bettsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Marie Moser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Charles Moser

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8 - 1878

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: housemother wife

11. Industry or business: Home

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: France

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: France

16. Informant: Rene S. Moser

Address: Bettsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Washington, D.C.

18. Funeral director: Gude Bros. Co.

Address: Rockville, Md.

19. Nov 13 1945 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 13 45, at 8.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-11 1945, to 11-13 1945

and that I last saw h.er alive on 11-13 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Acute Cardiac dil.	
Due to: Pyuria, Myocarditis	1 Year
Bronchial Asthma	10 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B P Warren M. D. or other

Address: Laurel Md. Date signed: 11-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11284

Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince George's, Md.
City or town: Glenn Dale, Md. -RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 2 mo.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 yrs., 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1735- Willard St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES WILSON MOSLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Evelyn Mosely
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1899

8. AGE: Years	Months	Days	If less than one day
45	11	5	hrs. min.

9. Birthplace: Roanoke, Va. (Town, county, and state)
10. Usual occupation: waiter
11. Industry or business:
FATHER 12. Name: William Mosely (dec.
13. Birthplace: South Boston, Va.
MOTHER 14. Maiden name: Lula Barkon
15. Birthplace: Radford Co., Va.
16. Informant: decedent
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 21, 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: Robert G. McGuire
Address: 1820-9th St. N.W. Wash, D.C.
19. Nov. 21, 1945 (Date rec'd by registrar) Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21st 1945, at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14th 1939, to Nov. 21st 1945
and that I last saw h. Lm. alive on Nov 21st 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 yrs 4 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 11/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11285

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Md. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3513-Bunker Hill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3513-Bunker Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Motley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Cloud Motley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6th 1892

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James G. Beall
FATHER 13. Birthplace Md.
MOTHER 14. Maiden name Barbara A. Hefflin
MOTHER 15. Birthplace Md.
16. Informant Ida M. Smith
Address 4308-19th St. N.E. Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 5 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery
Location Bladensburg Rd. & D.C. Line
18. Funeral director William J. Malley
Address 3200-R.I. Ave. Mt. Rainier, Md.
19. Nov 4 1945 James Devers Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945; at 8:11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5 1945, to Nov. 2 1945
and that I last saw her alive on Oct. 30 1945

Immediate cause of death	DURATION
Carcinoma of Cervix of Uterus with multiple Cutaneous metastases	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE U. Bennett M.D. M. D. or other
Address 3303 Penn St Mt. Rainier Md. Date signed 11-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11286

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5th

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3906 Madison St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Philip L. Ordwein

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ora T Ordwein
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Feb 17, 1891

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: U. S. Government

FATHER
12. Name: Geo. Philip Ordwein
13. Birthplace: Germany

MOTHER
14. Maiden name: Dorothy Meyers
15. Birthplace: Maryland

16. Informant: Mrs Ora T Ordwein
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19, 1945 (month) (day) (year)
Cemetery or crematory: Geo. Washington
Location: Berwyn Maryland

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland

19. Nov 18 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16, 1945 at 4;55 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 7 1945, to Nov 16 1945
and that I last saw h alive on Nov 16 1945

Immediate cause of death	DURATION
Carcinoma of prostate	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos. E. Semmes M.D.
Address: Nov 16/45 Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

11287

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georgis

City or town: Riverdale ~~Md~~

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ yrs

Hospital, Institution, or street address where death occurred: 6112 - 44th pl.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georgis

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6112-44th place.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Katherine Kaufman Parker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Joseph K. Parker.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 8 1854

8. AGE: Years	Months	Days	If less than one day
91	9	21	....hrs. ....min.

9. Birthplace: Richmond Va

(Town, county, and state)

10. Usual occupation: Housewife at home.

11. Industry or business:

FATHER 12. Name: Jesse D. Kaufman

FATHER 13. Birthplace: Richmond Va

MOTHER 14. Maiden name: Sallie Seltzer

MOTHER 15. Birthplace: Baltimore

16. Informant: Paul K. Rider

Address: 6112-44th pl., Riverdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: C. William Lees Sons Co.

Address: 300-4 St N.E. Washington DC

19. Nov 27 1945 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1945, at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1942, to Nov 26 1945, and that I last saw her alive on Nov 25 1945.

	DURATION
Immediate cause of death: Cerebral Thrombosis	1 week
Due to: General arteriosclerosis	25 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L W Nadler MD

M. D. or other

Address: Riverdale, Md Date signed: 11-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

11288

Reg. Dist. No. 229

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred: Warren's Hosp.

How long in hospital or Institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Ammendale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ammendale Normal Institute

(If rural, give LOCATION)

2.(a) If veteran, name war: N.D.

3.(a) FULL NAME Brother Telecian Patrick

3.(b) Social Security Number x x x

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: x x x

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1874

8. AGE: Years	Months	Days	If less than one day
71	7	13	....hrs. ....min.

9. Birthplace: Newark, Ohio (Town, county, and state)

10. Usual occupation: Clergyman

11. Industry or business

FATHER 12. Name: Bernard McLaughlin

13. Birthplace: Ireland

MOTHER 14. Maiden name: Bridget O'Shea

15. Birthplace: Ireland

16. Informant: Hosp. record

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/1945 (month) (day) (year)

Cemetery or crematory: Brothers Cemetery

Location: Ammendale Md.

18. Funeral director: W. W. Chambers Leo.

Address: Riverdale Md.

19. Nov 26 1945 (Date rec'd by registrar) M. Bushrod Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1945, at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1945, to Nov 25 1945

and that I last saw him alive on Nov 23 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arteriosclerosis	5-Yrs
Due to:	
Other conditions: Carcinoma Sigmoid Colon	2 Yrs

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Warren M.D.

M. D. or other

Address: Laurel Date signed 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
NOV 30 1995
U.S.

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

VS A15

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T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

11289

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death Permanent

Hospital, institution, or street address where death occurred: Old Brandywine Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Trenton Proctor

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 13, 1926

8. AGE:

Years	Months	Days	If less than one day
19	4	6	hrs. min.

9. Birthplace Upper Marlboro, Maryland (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business School Board

FATHER 12. Name Joseph H. Proctor

13. Birthplace Maryland

MOTHER 14. Maiden name Mary E. Newman

15. Birthplace Maryland

16. Informant Joseph H. Proctor

Address Upper Marlboro, Md

17. Burial Date thereof 11-21-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro, Md.

18. Funeral director Ritchie Bros

Address Upper Marlboro, Md.

19. Nov. 20 1945 F. H. Billingsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1945, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death Hemorrhage and shock

Due to Fractured skull, Crushed chest

Due to Fracture right femur

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-19-45

Where did injury occur? Brandywine P. G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where) Old Brandywine Rd

Means of injury: Driving a cart hit by a tree. Injured at work?

Deputy Medical Examiner

23. SIGNATURE James T. Boyd M. D. or other

Address Westwood ... Date signed 11-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

11290

CERTIFICATE OF DEATH

Reg. Dist. No. 240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince Georges
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: On County Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Melwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Louise Proctor
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): November 1927

8. AGE: Years: 18 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Piscataway, Maryland (Town, county, and state)
10. Usual occupation: Dishwasher
11. Industry or business: Restaurant
FATHER
12. Name: John A. Proctor
13. Birthplace: Maryland
MOTHER
14. Maiden name: Elizabeth V. Proctor
15. Birthplace: Maryland
16. Informant: John A. Proctor
Address: Melwood - Md.
17. Burial. Date thereof: 11-23-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro, Md.
18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.
19. Nov. 20 1945 F. H. Billingsley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1945, at 1:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Fractured skull, Fracture right humerus and femur	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 11-19-45
Where did injury occur? Brandywine P.G. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): County Road
Means of injury: Passenger car hit Injured at work? No
Deputy Medical Examiner
23. SIGNATURE: James H. Boyd M. D. or other
Address: Forestville, Md. Date signed: 11-19-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

11291 245

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days.

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges.

City or town: Hyatts'ville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4303 Oglethorpe St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Bessie Lee Reed.

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband or wife: George Lubcamm Reed

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 14 1860

8. AGE: Years: 85 | Months: 11 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick (C) Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Fred Gov.

FATHER
12. Name: James Torney
13. Birthplace: Adamstown, Pa.

MOTHER
14. Maiden name: Abbie Shoemaker.
15. Birthplace: Frederick Co. Md.

16. Informant: Daughter in-law-Mrs I Reed.
Address: 4303 Oglethorpe St. Hyatts Md

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 3" 1945
(month) (day) (year)

Cemetery or crematory:

Location: Washington DC

18. Funeral director: Martin F. Hyson Co
Address: 1308. N St N.W.

19. Nov 13 1945 James Lewey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1945, at 4.10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Nov 3 1945 and that I last saw h... alive on Nov 3 1945

	DURATION
Immediate cause of death: Cerebral apoplexy	3 wks
Due to: Arterial sclerosis	
Due to:	
Other conditions: Pulmonary edema	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos E Lawrence M. D. or other

Address: 4408 Ingleside Hyattsville Md Date signed: Nov 3 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11292

Reg. Dist. No. 2445

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges.

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3809 - Taylor street.

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: Walter A. Rhyndress

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ethel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 8th 1887

8. AGE: Years	Months	Days	If less than one day
58	0	22	..... hrs. ..... min.

9. Birthplace: Huntsville Canada (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Walter Rhyndress

13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Jennie

15. Birthplace: N.J.

16. Informant: Mrs Ethel Rhyndress

Address: 3809 - Taylor st. Brentwood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 3, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Bladensburg Md.

18. Funeral director: H. H. Chambers Co.

Address: Riverdale Md.

19. Nov. 30 1945 (Date rec'd by registrar) James Severs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30th 1945, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1945 to November 29 1945 and that I last saw h.. alive on November 29, 1945

Immediate cause of death	DURATION
Carcinoma of Pancreas with Metastasis to liver	Several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Pancreas with Metastasis to liver. Date of op. 9-28-45 Died suddenly

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Mt Rainier Md. Date signed 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11293

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH: County: Prince Geo (WITHIN CORPORATE LIMITS OF) City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Prince Geo

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Talbot Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ~~Katie Patricia~~ Catherine Robison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Walter Robison

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 27 1866

8. AGE: Years: 79 Months: 6 Days: 7 If less than one day: hrs. min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER — 12. Name: unknown — 13. Birthplace: "

MOTHER — 14. Maiden name: " — 15. Birthplace: "

16. Informant: Mrs Walter Robison Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 3-45 (month) (day) (year)

Cemetery or crematory: St Marys

Location: Laurel Md

18. Funeral director: Lloyd Lauer

Address: Laurel Md

19. December 3 1945 (Date rec'd by registrar) Cora E. Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-30 1945; at 7.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1 1944 to 11-30 1945 and that I last saw h-e alive on 11-28 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Possible Chest Neoplasm	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B Pickerell M. D. or other

Address: Laurel Md Date signed: 12-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11294

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Lincoln
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Lincoln
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Cornelia D. Scott

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: P.A. Scott
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): October 10th, 1865

8. AGE: Years	Months	Days	If less than one day
80		26	hrs. min.

9. Birthplace: West Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER — 12. Name: William Chinn
13. Birthplace: Md.

MOTHER — 14. Maiden name: Judia Copeland
15. Birthplace: West Va.

16. Informant: P.A. Scott
Address: Lincoln, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: Jeffery C. Gross
Address: 9th & H, N.E., N.W.
19. Nov. 7 1945 (Date rec'd by registrar) Mrs. Jeff. Barnett, D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6 1945, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1945, to Nov. 6 1945
and that I last saw h[er] alive on Nov. 4 1945

Immediate cause of death	DURATION
Cardiac Dilatation	2 days.
Due to: Coronillar Fibrillation	2 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Henry S. Johnson, M. D. or other
Address: Bowie, Md. Date signed: 11-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos., 20 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1328 Trinidade Ave., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: EDWARD CHARLES SCHADE

3.(b) Social Security Number: 577-09-6968

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Lilia C. Schade
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 6, 1908

8. AGE: Years	Months	Days	If less than one day
37	10	12	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business:
FATHER 12. Name: Henry C. Schade
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary E. Hurley
15. Birthplace: Washington, D. C.
16. Informant: Decedent
Address:
17. (Burial, cremation, or removal. Which?) Removal to Date thereof: 11-19-45 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: T. F. Costello
Address: 1722 - North Cap. St.
19. Nov. 18, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1945, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29, 1944, to Nov 18, 1945; and that I last saw h...i...M...alive on Nov 18, 1945.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr 5 da
Due to: Tuberculous Empyema	1 yr 5 da
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD
M. D. or other
Address: Glenn Dale, Md. Date signed: 11/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11295

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's, Maryland
City or town: Glenn Dale, Md., RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1809- Riggs Pl., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LILA SCOTT

3.(b) Social Security Number: none

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Andrew Scott
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): August 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	26	..... hrs. ..... min.

9. Birthplace: Culpepper, Virginia
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: -

FATHER
12. Name: Thornton Fitzhugh
13. Birthplace: Culpepper, Va.

MOTHER
14. Maiden name: Celia Brown
15. Birthplace: Culpepper, Va.

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11-20-45 (mouth) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: Frazier Funeral Home
Address: 389 R.I. ave NW

19. Nov. 20, 19 45 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 20 19 45 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 9 19 45 to NOVEMBER 20, 1945 and that I last saw h.. alive on NOVEMBER 20 19 45

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 MOS
Due to	
Due to	
Other conditions DIABETES MELLITUS	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11297

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 17 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 8 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2129 - 15th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: ARCHIE L SIMMONS

3.(b) Social Security Number: 238-24-8779

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 5, ~~1945~~ 1924

8. AGE: Years	Months	Days	If less than one day
21	-	4	hrs. min.

9. Birthplace: Concord, North Carolina
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Tom Simmons
13. Birthplace: Concord, North Carolina

MOTHER
14. Maiden name: Laura Allsbrooks
15. Birthplace: Concord, North Carolina

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-10-45 (month) (day) (year)

Cemetery or crematory: to Wash. dnd N.C.

Location:

18. Funeral director: R. N. Horton

Address: 1322 you. St N.W.

19. Nov. 9 19 45 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1945, at 9:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 1945 to November 9 1945 and that I last saw h. M. alive on November 9 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 MO 2 da
Due to: Syphilis	1 yr 4 MOS
Due to: Bronchopleural fistula due to the	3 mos.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on G 99 11-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-A)

CERTIFICATE OF DEATH

★1129 8245 Reg. Diat. No.

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: Md. County: Prince George
City or town: Mount Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3110 Upshur St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mamie Tindlul Smith.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	

6.(b) Name of husband or wife: Warren Ewen Smith
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 26, 1872.

8. AGE:	Years	Months	Days	If less than one day
73	74	9	12	____ hrs. ____ min.

9. Birthplace: Philadelphia, Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Connecticut
FATHER 12. Name: John Wesley Edwards
13. Birthplace:
MOTHER 14. Maiden name: Merriah Hunter
15. Birthplace: Philadelphia
16. Informant: Owner.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 16 1945 (month) (day) (year)
Cemetery or crematory: George Washington Memorial
Location: Berwyn Md
18. Funeral director: F. Gasch's Sons
Address: Hyattsville md
19. Nov 15 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 November 1945 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-2 1945 to 11-14 1945
and that I last saw h[illegible] alive on 11-13 1945

Immediate cause of death	DURATION
Hypostatic Cardiac Nervous Renal Disease	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underlioe the canse to which death should be charged statistically.

22. VIOLENCE: If death waa due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Brueger M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed: 11-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11299

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Clemell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Fairhaven

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wesley Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1941.

8. AGE: Years 4 | Months 1 | Days 5 | If less than one day hrs. min.

9. Birthplace District of Columbia (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name James Robert Smith

13. Birthplace Maryland

MOTHER 14. Maiden name Sadie Pannebaker

15. Birthplace District of Columbia

16. Informant James R. Smith

Address Fairhaven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12 1945 (month) (day) (year)

Cemetery or crematory St Johns Cemetery.

Location Beltsville Md.

18. Funeral director F. Gaschi sons

Address Hyattsville Md.

19. 11/10 1945 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....; and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Compound fracture	
of skull	
Due to Fracture of radius	
and ulnar right Arm	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-9-45

Where did injury occur? Clemell (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Landover Rd

Means of injury Jeep turning Over Injured at work? No

23. SIGNATURE Deputy Medical Examiner

M. D. or other

Address Hyattsville Md. Date signed 11-9-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

11300

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5510 - 44 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gertrude Frances Soules

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Fred Soules
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 15, 1871.

8. AGE: Years	Months	Days	If less than one day
73	—	—	hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business:

FATHER
12. Name: John Robert Pennell
13. Birthplace: Austintown, Ohio.

MOTHER
14. Maiden name: Emma Eva Mullens
15. Birthplace: Warren, Ohio.

16. Informant: Mrs Josephine E.B. Wilson
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 27 1945 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.

18. Funeral director: J. Gaston Sons
Address: Hyattsville Md.

19. Nov 27 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944 to Nov 24 1945 and that I last saw h-- alive on Nov. 20 1945

Immediate cause of death	DURATION
Myocardial Insufficiency	
Due to: Acute Myocardial Degeneration.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. A. Reed M. D. or other
Address: Hyattsville Md. Date signed: 11-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11301

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Chevery
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: —
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo.
City or town: Riverdale,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5414 Riverdale Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Millard H. Sutton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Estelle Sutton
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Feb 4 - 1884

8. AGE: Years	Months	Days	If less than one day
61			....hrs. ....min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Vincent Sutton
13. Birthplace: Virginia

MOTHER
14. Maiden name: Theodosia Harrison
15. Birthplace: Virginia

16. Informant: Thomas V. Howes
Address: 5414 Riverdale Rd., Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co
Address: River Dale Md.

19. 11/19/45 (Date rec'd by registrar) Amanda Vedre Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1945, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1945 to November 17 1945 and that I last saw h.. l.. alive on November 17, 1945

Immediate cause of death	DURATION
Acute Congestive heart failure	Several hours.
Due to: Coronary Heart Disease	Several days.
Due to:	
Other conditions: Pleuritis	Sev. months.
Artificial left limb.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or coroner
Address: Mt. Rainier, Md. Date signed 11-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

11302

Reg. Dist. No. 230 >31

1. PLACE OF DEATH:
County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
2-H Northway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2-H Northway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CATHERINE M. TEEL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John R. TEEL
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): August 24, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	22	...hrs. ...min.

9. Birthplace: Plumersville, Conway County, Ark. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER — 12. Name: Edgar H. Major
13. Birthplace: Alpine, Georgia
MOTHER — 14. Maiden name: Henry Estella Combs
15. Birthplace: Kenton, Tenn.
16. Informant: John R. Teel
Address: 2-H Northway, Greenbelt, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 17 1945 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Beltsville, Md
18. Funeral director: F. Gascha Sons
Address: Hyattsville Md
19. 11/17 19 45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1945, at 140 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1944 to November 15 1945 and that I last saw her alive on November 15, 1945

Immediate cause of death	DURATION
Chronic Leukemia	
Lymphatic Leukemia	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hans Wordak, M. D.
M. D. or other
Address: 30-D Ridge Rd, Greenbelt Md. Date signed: 11-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

11303

CERTIFICATE OF DEATH

FILM No. I 00 FEB 7 1946

Reg. Dist. No. 2 4 2

1. PLACE OF DEATH:

County: Prince Georges'

City or town: Chapel Oaks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1414 - 57" Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Alabama County: Madison

City or town: Huntsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jinks Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1877

8. AGE:

Years	Months	Days	If less than one day
68	2	6	..... hrs. ..... min.

9. Birthplace: Huntsville, Ala.

(Town, county, and state)

10. Usual occupation: Fireman, R.R.

11. Industry or business

FATHER 12. Name: Duncan Thompson

13. Birthplace

MOTHER 14. Maiden name: Anna ?

15. Birthplace ?

16. Informant: Almeta Evans

Address: 1414 - 57" Place

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/45 (month) (day) (year)

Cemetery or crematory: Paynes Cemetary

Location: 4640 Benning Rd., S.E. - Wash., D.C.

18. Funeral director: George W. Lewis & Co.

Address: 1225-11th Street, N.W.

19. 11-12 (Date rec'd by registrar) 19 45 Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1945 at 10 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 11, 1945 to Nov. 11, 1945 and that I last saw him alive on D. O. A., 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions: Paralized rt. leg due to previous brain accident.	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John W. Robinson, M.D.

M. D. or other

Address: 901 Eastern Ave. Date signed 11/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11304

★ Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 21 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 - Defrees St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME BENJ. AMEN, THORNTON.

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Johanna Brown
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 19, 1885

8. AGE: Years	Months	Days	If less than one day
60	1	28	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Stock Clerk
11. Industry or business:
FATHER 12. Name: Benjamin Thornton
13. Birthplace: Unknown
MOTHER 14. Maiden name: Alice Thornton
15. Birthplace: Unknown
16. Informant: Decedent
Address:
17. Removal to (Burial, cremation, or removal. Which?) Date thereof 11-16-45 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: J. J. Stewart
Address: 930 H NE
19. Nov. 16, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16th 1945, at 11 50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26th 1945 to Nov 16th 1945 and that I last saw him alive on Nov 16th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 11/16/45

A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11305

Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 29 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2412 - 17th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: LEON WASHINGTON

3. (b) Social Security Number: 578-14-7536

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 29, 1919

8. AGE: Years	Months	Days	If less than one day
26	2	20	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Ada Washington
15. Birthplace: Orange County, Virginia

16. Informant: Decedent
Address:

17. Removal to
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 18, 1945
(month) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: W Ernest Jarvis Co
Address: 1432 You St NW

19. Nov. 18, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1945, at 3-8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20, 1945, to Nov 18, 1945 and that I last saw h. / M. alive on Nov 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs
Due to: Fatal Hemoptysis	2 da
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

11306

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred: [illegible]
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Prince George
City or town Hillside (If outside city or town limits, write RURAL and give nearest town)
Street No. 1211 61st ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Grace Whiteside

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband ~~or wife~~ Frank
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) 6-26-1893

8. AGE: Years	Months	Days	If less than one day
52			...hrs. ...min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual occupation H.W.
11. Industry or business
FATHER 12. Name Frank Franz
FATHER 13. Birthplace N.Y.
MOTHER 14. Maiden name almina Smith
MOTHER 15. Birthplace N.Y.
16. Informant Hospital Record
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/45 (month) (day) (year)
Cemetery or crematory Mt. Lenwen Cemetery
Location
18. Funeral director Jos. F. Birch's Sons
Address 3034 - M St, N.W. - Wash., D.C.
19. 11/8 1945 Amanda Dauney (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-45 19... at 1 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-15 1945 to 11-8 1945 and that I last saw her alive on 11-8-45 1945

Immediate cause of death	DURATION
Cachexia, toxemia	
Due to Intestinal obstruction,	
Due to Chronic Abdominal Carcinomatosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Jennings M.D.
M. D. or other
Address Prince Geo. Hosp. Cheverly, Maryland Date signed 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

11307

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 9 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1113 - O. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ERNESTINE WILLIAMS

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1920

8. AGE: Years	Months	Days	If less than one day
25	6	2	hrs. min.

9. Birthplace: Tampa, Florida (Town, county, and state)
10. Usual occupation: Private Seamstress
11. Industry or business:
FATHER 12. Name: Ernest Williams
13. Birthplace: Florida
MOTHER 14. Maiden name: Eddie Davis
15. Birthplace: Hartford, Conn
16. Informant: Decedent
Address:
17. Removal to Wash D.C. Date thereof: 11-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Robert E. McGuire
Address: 1820 9th N.W.
19. Nov. 27 1945 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 27 1945 at 4:48 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 18 1945 to Nov. 27 1945; and that I last saw h. E.R. alive on NOVEMBER 27 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Eastern Ave., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Williams, Genevive

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Anderson, Williams

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): March 21, 1924

8. AGE:

Years	Months	Days	If less than one day
21	8	14	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Clerk in Dry Cleaning Estab.

11. Industry or business:

FATHER
12. Name: William Morton
13. Birthplace: Caroline Co., Virginia

MOTHER
14. Maiden name: Hannah Roye
15. Birthplace: Caroline Co., Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11 26 45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Robert H. McGuire

Address: 1820 9 St. N.W.

19. Nov. 26 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-26 1945 at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-29 1945 to 11-26 1945 and that I last saw h... alive on 11-26 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	5 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

11304

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George General Hospital
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 56 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5505 Farragut ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen Pringle Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	married

6.(b) Name of husband ~~or wife~~: William Wilson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8 - 1905

8. AGE: Years	Months	Days	If less than one day
39	10	25	hrs. min.

9. Birthplace: Maine (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business
12. FATHER — Name: Henry M. Pringle
13. FATHER — Birthplace: Vermont
14. MOTHER — Maiden name: Emma Prescott
15. MOTHER — Birthplace: Vermont
16. Informant:
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/45 (month) (day) (year)
Cemetery or crematory:
Location: Waterville Maine
18. Funeral director: Wm. Tees Sons Co
Address: 1300 4 St NE DC
19. 11/25 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 25 1945 at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20th 1945 to November 26 1945 and that I last saw h~~er~~ alive on November 25th 1945

Immediate cause of death	DURATION
Metastatis c.a. of brain	
Due to: Oklahoma unequally then multiple metastatis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: Prince Geo Gen Hosp Cheverly Md. Date signed: 11-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11310

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 57½ Hanover St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: WOOD ELOISE

3. (b) Social Security Number: 579-03-0963

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6.(b) Name of husband or wife: Henry Wood

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 8, 1904

8. AGE: Years	Months	Days	If less than one day
41	9	16	...hrs. ...min.

9. Birthplace: Charlotte, North Carolina
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business:

FATHER
12. Name: J. Holly
13. Birthplace: Charlotte, North Carolina

MOTHER
14. Maiden name: Alice Harden
15. Birthplace: Charlotte, North Carolina

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 25 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: Walter L. Scher Inc.

Address: 424 - R St NW

19. Nov. 24 19 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24, 1945, at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/24 1945, to 11/24 1945 and that I last saw h.. alive on 11/24 1945

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15